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EXAMINER	
HARLE, JENNIFER I	

ART UNIT	PAPER NUMBER
3627	# 20

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Please find below and/or attached an Office communication concerning this application or proceeding.

Office Action Summary	Application No. 09/443,072	Applicant(s) ROSENFELD MD ET AL
	Examiner Jennifer I. Harle	Art Unit 3627

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If the period for reply specified above is less than thirty (30) days, a reply within the statutory minimum of thirty (30) days will be considered timely.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133).
- Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

1)☒ Responsive to communication(s) filed on *23 October 2003*.

2a)☐ This action is **FINAL**. 2b)☒ This action is non-final.

3)☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

4)☒ Claim(s) *15,17-19 and 21-29* is/are pending in the application.

4a) Of the above claim(s) _____ is/are withdrawn from consideration.

5)☐ Claim(s) _____ is/are allowed.

6)☒ Claim(s) *15,17-19 and 21-29* is/are rejected.

7)☐ Claim(s) _____ is/are objected to.

8)☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

9)☐ The specification is objected to by the Examiner.

10)☐ The drawing(s) filed on _____ is/are: a)☐ accepted or b)☐ objected to by the Examiner.

Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).

Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).

11)☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. §§ 119 and 120

12)☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).

a)☐ All b)☐ Some * c)☐ None of:

1.☐ Certified copies of the priority documents have been received.

2.☐ Certified copies of the priority documents have been received in Application No. _____.

3.☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

* See the attached detailed Office action for a list of the certified copies not received.

13)☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. § 119(e) (to a provisional application) since a specific reference was included in the first sentence of the specification or in an Application Data Sheet. 37 CFR 1.78.

a) ☐ The translation of the foreign language provisional application has been received.

14)☐ Acknowledgment is made of a claim for domestic priority under 35 U.S.C. §§ 120 and/or 121 since a specific reference was included in the first sentence of the specification or in an Application Data Sheet. 37 CFR 1.78.

Attachment(s)

1) ☒ Notice of References Cited (PTO-892)
2) ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
3) ☐ Information Disclosure Statement(s) (PTO-1449) Paper No(s) _____ .
4) ☐ Interview Summary (PTO-413) Paper No(s). _____ .
5) ☐ Notice of Informal Patent Application (PTO-152)
6) ☐ Other: .

DETAILED ACTION

Claims 15, 17-19, 21-29 are pending. Claims 15, 17-19, 21-29 are rejected.

Claim Rejections - 35 USC § 112

The following is a quotation of the second paragraph of 35 U.S.C. 112:

> The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter which the applicant regards as his invention.

Claim 28 rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention. Claim 28 recites the limitation "the means for transmitting voice and data" in lines 2-3. There is insufficient antecedent basis for this limitation in the claim.

Claim Rejections - 35 USC § 112

Although Applicant(s) use "means for" in the claim(s) (e.g. claim 28), it is the Examiner's position that the "means for" phrase(s) do not invoke 35 U.S.C. 112 6th paragraph. If Applicant(s) concur, the Examiner respectfully requests Applicant(s) to either amend the claim(s) to remove all instances of "means for" from the claim(s), or to explicitly state on the record why 35 U.S.C. 112 6th paragraph should not be invoked.

Alternatively, if Applicant(s) desire to invoke 35 U.S.C. 112 6th paragraph, the Examiner respectfully requests Applicant(s) to expressly state their desire on the record. Upon receiving such express invocation of 35 U.S.C. 112 6th paragraph, the "means for" phrase(s) will be interpreted as set forth in the *Supplemental Examination Guidelines for Determining the Applicability of 35 USC 112 6th Paragraph.*[1]

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[1] Federal Register Vol. 65, No 120, June 21, 2000.

Failure by Applicant(s) to address the 35 U.S.C. 112 6th paragraph issues in the manner set forth above or to be non-responsive to this issue entirely will be considered a desire by Applicant(s) NOT to invoke 35 U.S.C. 112 6th paragraph.

Claim Rejections - 35 USC § 103

The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

> (a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negatived by the manner in which the invention was made.

1. Claims 15 and 18 are rejected under 35 U.S.C. 103(a) as being unpatentable over Buxton, et al. (3,646,606) or Reuss, et al. (6,364,834) in view of Lee (4,838,275). Claim 17 is rejected under 35 U.S.C. 103(a) as being unpatentable over Reuss, et al. (6,364,834) in view of Lee (4,838,275). Buxton, et al. and Reuss, et al. teach as set forth in the table below. Items in bold are not disclosed by Buxton, et al. Items in italics are not disclosed by Reuss, et al.

Claim 15. (Twice Amended) A system for providing continuous and proactive expert network health care services from a remote location comprising:	Buxton, et al. – Physiological monitoring system of patients in a hospital (Abstract), Every Patient Continuous Monitoring, including preshock indications, i.e. "proactive monitoring"((col. 2, lines 33) is transmitted to a central monitor (remote location) col. 1, lines 62-63). Reuss, et al. – the central monitoring system also monitors incoming data from the patient monitor for medical alert messages, and continually monitors incoming data from the patient monitor for possible emergency situations (col.1, lines 42-45), remotely monitors patient parameter (col. 7, lines 47-58), comprehensive trending of parameters, including a 24 hour trending, i.e. proactive

	monitoring (col. 9, lines 38-45), caregiver can initiate a more detailed analysis of the viatal signs, i.e. intervention (col. 16, lines 41-43).
A plurality of geographically dispersed ICU's;	Buxton, et al. - Plurality of intensive care patient units (Fig. 1 – 10), each patient is equipped with a patient measurement unit 10 … patients may be in separate rooms, making unnecessary a special location for patients requiring intensive care (col. 2, lines 21-24). Reuss, et al. - Plurality of critical care patient monitors, critical care is equivalent to ICUs (Fig. 1 – 16, col. 5, lines 8-10, col. 7, lines 15-25).
A single remote ***intensivist*** managed healthcare command center for managing healthcare at said plurality of ICU's; and	Buxton, et al. - System of the invention as applied to an intensive care application … are monitored, i.e. central monitor (Fig. 1-12), by a single medical observer. Reuss, et al. – central monitor (Fig. 1-14) displays information to a medical caregiver (col. 4, lines25-26), plurality of critical care patient monitors, critical care is equivalent to ICUs (Fig. 1 – 16, col. 5, lines 8-10, col. 7, lines 15-25).
At least one network;	Buxton, et al. - Data communication over a network (Fig. 1). Reuss, et al. – Network (Fig. 1 –10).
Wherein said plurality of ICU's include means for transmitting **voice** and data to said remote command center by the at least one network,	Buxton, et al. – Plurality of intensive care patient units (Fig. 1 – 10), each patient is equipped with a patient measurement unit 10 … patients may be in separate rooms, making unnecessary a special location for patients requiring intensive care (col. 2, lines 21-24), transfers patient data over network to central monitor (12) (Fig. 1). Reuss, et al. - plurality of critical care patient monitors, critical care is equivalent to ICUs (Fig. 1 – 16, col. 5, lines 8-10, col. 7, lines 15-25), transfers patient data over network (Fig. 1 – 10, 14, col. 4, lines 5-21 and 55-67).

And wherein said remote command center further comprises at least one ***intensivist*** workstation connected to a computerized patient care management system **adapted for** proactive monitoring and **intervention** for individual patients at any of said plurality of geographically dispersed ICU's 24 hours per day, seven days a week, triggered by evidence-based data-driven feedback.	Buxton, et al. – command center having medical observer workstation (Fig. 1- 12 and Fig.3, cols. 3-4, lines 53-36), continually monitors patients (Fig. 1 – 16, Every Patient Continuous Monitoring including preshock indications, i.e. "proactive monitoring"(col. 2, lines 33) is transmitted to a central monitor (remote location) col. 1, lines 62-63), triggered by evidence-based data driven feedback is the Every Patient Continuous Monitoring-which measures physiological conditions pertinent to the ailment , .i.e. permits the preset of critical limits for a given patient as determined by his doctor and thus provides selective critical care for that patient, can be in the form of warnings/alarms, overvoltage output, biasing effects, or readouts. 24/7 is another way of stating "continuous" monitoring; further is inherent that every ICU is staffed 24/7 and that once an alarm or warning is triggered in an ICU monitoring system intervention would occur, even if it is only to comply with a DNR and note time of death. Reuss, et al. – command center having caregiver workstation (Fig. 4, col. 4, lines 5-41), the central monitoring system also monitors incoming data from the patient monitor for medical alert messages, and continually monitors incoming data from the patient monitor for possible emergency situations (col.1, lines 42-45), remotely monitors patient parameter (col. 7, lines 47-58), comprehensive trending of parameters, including a 24 hour trending, i.e. proactive monitoring (col. 9, lines 38-45), transmission of a message typically indicative or an alert entered manually/automatically or caregiver can initiate a more detailed analysis of the vital signs, i.e. intervention (cols. 15-16, lines 61-14, col. 16, lines 41-43) is triggered by evidence-based data-driven feedback, i.e. the monitored and recorded patient parameters and includes audible and visual alarms – 24/7 is

	another way of stating "continuous monitoring."
Claim 18. (Previously Amended) The system for providing continuous and proactive expert network health care services from a remote location of claim 15 wherein each of the plurality of geographically dispersed ICU's further comprises patient monitoring equipment electronically connected to the remote command center over the network.	Buxton, et al. – teaches that each of the patients monitored would be provided a patient monitoring unit which would electrically sense two or more physiological conditions, translate desired information into digital form and transmit it by pulse coded FM radio link to a central monitoring station, i.e. wirelessly electronically connected (Abstract). Reuss, et al. – comprising at least one patient monitor, at least one central monitor, and at least one remote access device which are tied together through an integrated communication link (Abstract), preferably linked in a network which comprises a RF system, most preferably frequency-hopping, spread spectrum RF communications in the ISM frequency band, may include other wireless communications systems, including IR (cols. 3-4, lines 63-4).
Claim 17. (Previously Amended) The system providing continuous and proactive expert network healthcare services from a remote location of claim 15, wherein said computerized patient care management system further comprises a data server/data warehouse for storing and analyzing data from the remote command center.	Reuss, et al. – the central monitoring system comprises … and a memory storage. … and stores the data for archival and analysis purposes. (col. 4, lines 22-27) – This is by definition a "server" as a server is defined.[2]

Buxton, et al. does not specifically teach:

[2] The Microscoft Press Computer Dictionary Third Edition, 1997, pg. 430, defines a server as a computer or program on the Internet of other network that responds to commands from a client, i.e. a file server may contain an

1) that the "medical observer is an "intensivist";

2) that the network transmits "voice" to the command center; and

3) that the workstation is adapted for "intervention."

Lee teaches a home medical surveillance system or patients that has a control office that is remote from patients homes where there is a trained observer enabled to determined the general state of health of substantially each one of the many patients and also to determine from this information whether a nonroutine therapeutic response should be provided for substantially each patient (col. 6, lines 3-40). Additionally, Lee teaches that much of the information obtained by the system is not amenable to computerized analysis and thus the observer is essential for the interpretation of these data, i.e. the ballistocardiogram, electrocardiogram, impedance pneumogram and DUSIAP trace must all be interpreted by a professional (the observer, or "intensivist") who compares the new data to the stored baseline tracings, as well as lung sound requiring human monitoring (col. 12, lines 54-61). Lee further teaches that the monitoring network includes voice communication with the patient (col. 12, lines 61-63).

It would have been obvious to one of ordinary skill in the art at the time of the invention to man the monitoring station in Buxton, et al. with an "intensivist" as the medical observer because lee teaches it would be advantageous to have the data read by a professional (i.e., an intensivist) as it is essential for the correct interpretation of the data.

It would have been obvious to one of ordinary skill in the art at the time of the invention to also include voice communication in Buxton, et al. because Lee teaches using voice communication to allow the "intensivist" to talk to is another important function of the observer,

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archive of data or program files; when a client submits a request for a file, the server transfers a copy of the file to

as it permits obtaining better assessment during the diagnosis, as well as determining the urgency of the situation/ providing guidance to the patient (col. 12, lines 61-63 and col. 16, lines 49-51).

Assuming arguendo that there is no means for intervention at the remote station of Buxton, et al., Lee teaches that the work station is adapted for intervention as there are three system progress display units used during emergencies and the control board has fifty event buttons in response to initiate a preprogrammed sequence of events, including simultaneous calls to the paramedics and to the distressed patient's physician in order to reduce response times (col. 13, lines 18-34).

It would have been obvious to one of ordinary skill in the art at the time of the invention to also include means for intervention at the workstation because (1) Buxton, et al. is in a hospital environment an all hospitals have a "means for intervention" at the monitoring stations, such as paging functions for emergency intervention at least for liability reasons and (2) Lee teaches that the event function buttons allow the observer to initiate intervention events more quickly thus reducing the response time.

Reuss, et al. does not specifically teach that the caregiver is an "intensivist." Lee teaches a home medical surveillance system or patients that has a control office that is remote from patients homes where there is a trained observer enabled to determined the general state of health of substantially each one of the many patients and also to determine from this information whether a nonroutine therapeutic response should be provided for substantially each patient (col. 6, lines 3-40). Additionally, Lee teaches that much of the information obtained by the system is not amenable to computerized analysis and thus the observer is essential for the interpretation of

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the client.

these data, i.e. the ballistocardiogram, electrocardiogram, impedance pneumogram and DUSIAP trace must all be interpreted by a professional (the observer, or "intensivist") who compares the new data to the stored baseline tracings, as well as lung sound requiring human monitoring (col. 12, lines 54-61). Lee further teaches that the monitoring network includes voice communication with the patient (col. 12, lines 61-63).

It would have been obvious to one of ordinary skill in the art at the time of the invention to man the monitoring station in Buxton, et al. with an "intensivist" as the medical observer because Lee teaches it would be advantageous to have the data read by a professional (i.e., an intensivist) as it is essential for the correct interpretation of the data.

As per claim 19, Buxton, et al. and Reuss, et al. teach all of the elements as set forth above. However, neither teach that each geographically dispersed ICU further comprises a nurses' station electronically connected to said monitoring equipment and to the remote command center over the at least one network. In the hospital world, the business practice of having nurses' stations electronically connected to the monitoring equipment over the a network is an old and well—established business practice. This practice is designed to facilitate patient monitoring, permit flexibility in the treatment of patients within the ICU environment and allow for staffing needs within the ICU ward. It would have been obvious to one of ordinary skill in the art at the time of the invention to include in the system of Buxton, et al./Reuss, et al. electronically connecting the nurses' station to the remote monitoring station as it would have created the benefits taught by Lee, i.e. quicker response times.

2. Claim method claim 25 is rejected under 35 U.S.C. 103(a) as being unpatentable over Buxton, et al. or Reuss, et al. in view of Lee as applied to claim 15 above, and further in view of Levin, et al. (5,724,580) or Benigno, et al. (6,230142).

The only difference between the method claim and the system claim is that the proactive intervention from the remote command center via at least one intensivist workstation is triggered by evidence-based data driven feedback from **decision support algorithms**. The use of decision support algorithms in intervention is not taught by either of the previous the combination of references set forth. However, both Levin (Summary of the Invention) and Benigno (Summary of the Invention) teach the use of clinical pathways using decision support algorithms to provide care for patients, i.e. intervention in patient care utilizing evidence-based data driven feedback from decision support algorithms, as the algorithms must have evidence-based data driven feedback in order to provide the patient care (intervention). Levin specifically teaches treating coronary diseases, therapeutic dosing, ischemia, lipids, cholesterol, and diabetes (See figures and Summary of Invention) utilizing a relational database. Benigno teaches hypertension, diabetes and vital signs (See figures and cols. 4-10). It would have been obvious to one of ordinary skill in the art at the time of the invention to include utilizing decision support algorithms in the intervention method because as taught by Levin the decision support algorithms optimize therapy and minimize cost (col. 10, lines 25-26).

System claim 21 is rejected for the same reasons set forth in method claim 25.

Claim 22 is rejected for the same reasons set forth in claims 21 and 25.

Claim 24 is rejected for the same reasons as claim 22. Levin teaches decision based algorithms for coronary diseases, Benigno teaches decision based algorithms for vital signs. Hemodynamic algorithms relate to the functioning of blood circulation.

As per claim 26, is rejected for the same reasons set forth in claim 25. Levin and Benigno teach the use of specific decision sport algorithms claimed as set forth above.

Claim 27 is rejected for the same reasons set forth in system claim 17.

3. Claim 23 is rejected under 35 U.S.C. 103(a) as being unpatentable over Buxton, et al. or Reuss, et al. in view of Lee as applied to claim 15 above, in view of Levin, et al. (5,724,580) or Benigno, et al. (6,230142) as applied to claim 25 above, and further in view of Surwitt, et al. (6,024,699).

The prior references teach as set forth above. However, they do not teach that the computerized patient care management system further comprises order writing software means for providing knowledge-based recommendations and prescriptions for medication based upon the clinical data. However, Surwit, et al. teaches that medical condition of a plurality of remotely located patients are monitored, diagnosed and prioritized (according to severity) and treated using a central processing system to communicate with and receive data from a plurality of respective patient monitoring system, including a medicine dosage algorithm (Abstract). Surwit futher teaches that these diseases include diabetes, implementation of medication dosage algorithms in cases where these algorithms are not a feature offered by patient monitoring systems and identification of emergency medical conditions (cols. 1-2). Surwit teaches that this system is advantageous because physicians and other healthcare providers can remotely monitor, identify and treat patient medical problems, thereby obviating the need for frequent patient visits

and telephone calls, facilitates automation of various aspects of patient treatment, are able to quickly identify patients with medical conditions requiring immediate attention from a patient population of thousands or more. These same benefits carry over into the remote monitoring ICU environment, where staff are free from frequent interruptions, quick patient identification is made possible, etc. It would have been obvious to one of ordinary skill in the art at the time of the invention to include order writing software means for providing knowledge-based recommendations and prescriptions for medication based upon the clinical data in the method for the reasons set forth by Surwit, albeit expanded for the ICU and is application to critical care and the ability to support the patient.

4. Claim 28 is rejected under 35 U.S.C. 103(a) as being unpatentable over Buxton, et al. or Reuss, et al. in view of Lee as applied to claim 15 above, in view of Levin, et al. (5,724,580) or Benigno, et al. (6,230142) as applied to claim 25 above, and further in view of Douglas A. Perednia, Telemedine Technology and Clinical Applicantions, The Journal of the American Medical Association, Vol. 6, February 8, 1995, pg. 483.

The prior references teach as set forth above. Lee teaches that certain monitoring, i.e. the ballistocardiogram, the electrocardiogram, the impedance pneumogram and DUSIAP trace must be monitored by the intensivist, as set forth above. However, they do not teach that transmitting voice and data further comprises transmitting video. Perednia teaches that more complex applications to telemedicine require one-way or two-way full-motion video. Perednia further teaches that telemedicine can be useful for situation in which physical barriers prevent the ready transfer of information between patients and health care providers; the availability of information is key to proper medical management and using the most efficient communications technology

for each medical application is important because equipment and communication costs are directly proportional to the amount of information to be transmitted. It would have been obvious to one of ordinary skill in the art at the time of the invention to include video in the method for the reasons set forth by Peredina in the telemedicine and is application to critical care as it would relate to surgery and the ability to support the patient.

Claim 29 is rejected for the same reasons as claim 28.

Conclusion

The prior art made of record and not relied upon is considered pertinent to applicant's disclosure.

Capuano, et al. – discloses that the availability of telemetry beds increased cost-effectively at Lehigh Valley Hospital Center by providing telemetry on medical/surgical units with remote monitoring at designated critical areas. 24 hour live coverage was supplied with beeper coverage for the initial two-week period.

Nenov, et al. – discloses that there is a significant demand by physicians and clinical researches for remote access to continuously acquire physiological patient data and that until recently such access was technically unfeasible. Nenov further teaches that most patient in intensive care require continuous supervised monitoring for extended periods of time, however, having nurses and doctors continuously available to analyze the datastream from the monitors is often far from reality, as physicians are rarely at a patient's bedside and nurses must continuously attend to multiple patents and may not easily access all physiologically relevant parameters without physically moving into the patient's room. Nenov discloses Internet communications tools for access and transmission to remote sites of continuously monitored

physiological parameters from post-surgical/post-traumatic patients at the neurosurgery intensive Care Unit. However, Nenov, does not teach the use of an intensivist.

Grundy, et al. – discloses that telemedicine can solve some problems related to the scarcity and maldistribution of specialists in critical care medicine, i.e. in ICUs.

Mabry, et al. – discloses an integrated suite of models and tools providing quantitative and dynamic analysis from physiological function models, clinical care patient input, medical device data, and Northrop Grumman medical products, including the use of algorithms.

Kaplan, et al. – discloses using the locales framework to identify problems and issues with existing practice and focuses discussion on possible solutions by illustrating a study of inter- and intra-ICU consultation practice across three hospital intensive care units.

Miksch – discloses how artificial intelligence could be used for decision support in modern intensive care units, namely using knowledge-based techniques, including monitoring and therapy planning.

In accordance with the USPTO's goals of customer service, compact prosecution, and reduction of cycle time, and because "the continual, chief complaint of inventors and their lawyers: that patent examiners are abysmal communicators, both orally and in writing,"[3] the Examiner has made every effort to clarify his position regarding claim interpretation and any rejections or objections in this application. Furthermore, the Examiner has provided Applicant(s) with notice—for due process purposes—of his position regarding his factual determinations and legal conclusions. If Applicant(s) disagree with *any* factual determination or legal conclusion made by the Examiner in this Office Action whether expressly stated or

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[3] Sabra Chartrand, *A Bid to Overcome Patent Backlogs*, 152 N.Y. Times C2 (Sept. 23, 2002).

implied,[4] the Examiner respectfully requests Applicant(s) *in their next response* to expressly traverse the Examiner's position and provide appropriate arguments in support thereof. Failure by Applicant(s) *in their next response* to traverse the Examiner's positions and provide appropriate arguments in support thereof will be considered an admission by Applicant(s) of the factual determinations and legal conclusion not expressly traversed.[5] By addressing these issues now, matters where the Examiner and Applicant(s) agree can be eliminated allowing the Examiner and Applicant(s) to focus on areas of disagreement (if any) with the goal towards allowance in the shortest possible time.

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Jennifer I. Harle whose telephone number is 703.306.2906. The examiner can normally be reached on Monday through Thursday, 6:30 am to 5:00 pm,.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, Robert Olszewski can be reached on 703.308.5183. The fax phone number for the organization where this application or proceeding is assigned is 703.872.9326.

Any inquiry of a general nature or relating to the status of this application or proceeding should be directed to the receptionist whose telephone number is 703.308.1113.

Jennifer Ione Harle
3627
November 24, 2003

[4] E.g., if the Examiner rejected a claim under §103 with two references, although not directly stated, it is the Examiner's implied position that the references are analogous art.
[5] See also MPEP §714.02, 37 CFR §1.111(b), and 37 CFR §1.104(c)(3).